**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

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| Requestor Name and Address:<br><br>DR AHMED KHALIFA<br>1415 SOUTH HIGHWAY 6 SUITE 400D<br>SUGARLAND TX 77478 | MFDR Tracking #: M4-10-1323-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Box #:<br><br>LIBERTY MUTUAL FIRE INSURANCE<br>Box #: 01 | Date of Injury:<br>Employer Name:<br>Insurance Carrier #: |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Requestor's Position Summary:** "Based on this E.O.B. the medical bill of $128.54 for the procedural code 99214 was denied. The rational for the denial was 'The charge was made on the same day as a surgical procedure or within 10 days follow up of a previously performed surgery.'" "Firstly, the date of this medical bill, August 06, 2009, is not the same day as any other procedure. Secondly, this patient did not have a surgical procedure. Thirdly, the patient had 'Radio-frequency ablation with destruction of neuromas in above knee stump of the right lower extremity'. In that respect it was medically necessary to be evaluated post procedure and as soon as possible for any complications."

**Amount in Dispute:** $128.54

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

**Respondent's Position Summary:** "Follow-up included in Procedure."

## PART IV: SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Calculations | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| 8/6/2009 | 99214 | Not Applicable | $128.54 | $0.00 |
| | | | **Total Due:** | $0.00 |

## PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Division rule at 28 TAC §133.307, titled *MDR of Fee Disputes*, effective May 25, 2008, sets out the procedures for health care providers to pursue a medical fee dispute.
2. Division rule at 28 TAC §134.203 titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 9/9/2009

   - U018-A charge was made for a visit on the same day as a surgical procedure, or within the 10 day follow up of a previously performed surgery.
   - 17-Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.

- W1-Workers Compensation State Fee Schedule Adjustment.

**Issues**

1. Does the Medicare policy on post-operative global fee periods apply to the service in dispute?
2. Did the requestor submit a medical bill for a surgical procedure to the respondent performed prior to the disputed office visit?
3. Did the requestor sufficiently support that the service in dispute is unrelated to the surgery and therefore payable?
4. Is the requestor entitled to reimbursement?

**Findings**

1. Division rule at 28 TAC §134.203(a)(5), titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare." According to Trailblazers Surgical Manual "Outpatient visits during the postoperative period are allowed during a global fee period if the claim documentation demonstrates that the visit is for a diagnosis unrelated to the original surgery. Use modifier 24 in this situation." "Office visits during the postoperative period are not covered unless they are submitted with modifier 24 to indicate they are unrelated to the surgery. Modifier 24 is primarily for use only by the surgeon. A different diagnosis code may be sufficient to show the procedure is unrelated to the surgery; however, it may not be required. Documentation submitted should fully explain how the E/M [Evaluation and Management] service is unrelated to the surgical procedure." Therefore the Medicare policy on post-operative global fee periods applies.
2. On August 4, 2009, the requestor billed the respondent for CPT code 64640 defined as "Destruction by neurolytic agent; other peripheral nerve or branch." According to Medicare's physician fee schedule, CPT code 64640 has a post-operative global fee period of 10 days. The documentation supports that CPT code 99214, was performed by the requestor on August 6, 2009. Therefore, the requestor performed an evaluation and management office visit within the 10-day global fee period.
3. A review of the medical documentation finds that the requestor billed for the same diagnoses codes on the disputed date of service (897.2-Traumatic amputation of leg(s) (complete) (partial) unilateral, at or above knee, without mention of complication; and 355.6-Mononeuritis of lower limb, lesion of plantar nerve) as the surgery performed on August 4, 2009. Additionally, no modifier was appended to the service in dispute. Therefore, the requestor failed to support that the service in dispute is unrelated to the surgery performed on August 4, 2009. For that reason, CPT code 99214 is not separately payable.
4. Based upon the medical documentation and bills submitted by both parties in this dispute, the Division finds that the disputed office visit is global to the August 4, 2009 surgery. Per Division rule at 28 TAC §134.203(a)(5), reimbursement is not recommended for the office visit coded 99214.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

**PART VI: ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

| Authorized Signature | Medical Fee Dispute Resolution Officer | Date |
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## PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**